

Cultural Competence in Treating Survivors of Trauma

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Trauma occurs within the psychosocial framework of external cultural realities, and the internal, intrapsychic representations of those realities. Trauma does not happen to a generic human being. It occurs in the context of who a person is, and the various and multiple strands of identity. A survivor experiences the distress of the trauma, and attempts to cope with that distress, in the psychosocial realities of a particular time, place, and location in the social and political world. Additionally, a therapist working with the trauma survivor is also the product of this process of identity development in the context of cultural and social realities, and represents meanings to trauma survivors that affect the development of a therapeutic alliance and the conduct of psychotherapy itself.

Responding effectively to these realities in clinical work requires the development of cultural competence. This goal has often seemed daunting, largely because of how cultural competence has most commonly been defined. This article presents an overarching stance about cultural competence that can be woven into the fabric of specific treatment models for working with trauma.

Why should work with trauma survivors be concerned with cultural competence? Why not see all trauma survivors as simply human, and take a stance of “color-blindness”? The answer - because the very nature of trauma is inherently concerned with culture, context, politics, and identity. Much trauma is interpersonal in nature, and each person comes to the experience of trauma, whether as perpetrator or target, as a human with identities and social relationships. In consequence, the violations of body, mind, and spirit at the core of many experiences of traumatic stress are each flavored and shaped by

those psychosocial, contextual, political, and cultural milieus in which that trauma occurs. Ironically, within a scholarly literature that attempts to give voice to silenced trauma survivors, discussions of culture, identity, and social context have largely been the invisible components of conceptualizations of working with trauma survivors.

I use the terms “target” and “agent” group in my discussion of cultural competence. Target groups are defined as those groups in a given cultural and political setting that have been historically, and/or are currently, the targets of systemic discrimination, violence, and/or prejudice. Agent groups are defined as those groups in a particular cultural and political setting that are defined as the norm, and which possess power within the hierarchy and institutions of that setting. Most individuals contain some mixture of agent and target experiences within their identities. Trauma survivors themselves constitute one large, otherwise diverse target group, marginalized by a larger culture that wishes to obscure the realities of human capacities for cruelty or the fact that life is full of risk and danger.

The 1970’s and 1980’s were marked by an explosion of scholarship on the psychological experiences and needs of target groups, with volumes dedicated to women, African-Americans, lesbians and gay men, older adults, people with disabilities, and other similar specific target groups. This sort of scholarship, which focuses on within-group similarities, as well as differences between target and dominant groups, is referred to as an *etic* epistemology. Variations of the “Handbook of Psychotherapy with Alien Others” were published.

Cultural competence of this sort required acquisition of large amounts of information about specific groups. A culturally competent practitioner in this model

would thus have specific limits to her/his competence, being able, for instance, to work well with Bajorans, but not with Klingons (both of these are imaginary ethnic groups from the television series *Star Trek*¹). This period was an important and necessary corrective to how it had been when “even the rat was white.” There were problems, though. Use of mainstream diagnosis was insufficiently addressed. A sort of conceptual ghetto was created in which the “diverse populations” literature flourished. One became culturally competent to work with Alien Others only if one had a special focus on Alien Others.

21st Century models are different. They do not assume an invariant human behavioral norm or standardized categories of understanding and analyzing human experiences. It became important not just to understand Alien Other clients, but also all aspects of a clinician’s or researcher’s identities. Cultural competence became more about cultural humility (knowing what you don’t know), cultural self-awareness (knowing that you do have biases, and understanding how they affect you), and empowerment of clients to define what is important to them. The construct of Aversive Bias is particularly important here. People who have not yet experienced trauma hold biases about those who have experienced trauma, similar to those held about other groups of people, and if those biases are hidden or unacknowledged they can affect quality of care for trauma survivors.

Aversive bias is non-conscious biases held by individuals who consciously eschew overt expressions of bias. Social psychologists who have studied this phenomenon extensively suggest that around 85% of Euro-American individuals hold

¹ Bajorans are an ethnic group from the television series *Star Trek: Deep Space Nine*. Like many earth target groups, they have a history of colonization, oppression, and resistance, making them an excellent fictive placeholder for actual target groups. Their colonizers and oppressors, the Cardassians, serve as the fictive placeholder for dominant groups.

aversive bias towards persons of color, for example, even though their consciously held attitudes and behaviors are devoid of overt bias. The presence of aversive bias in an individual has observable impact on their interactions with those towards whom the bias is held. Members of target will commonly experience their interactions with such aversively biased people as crazy-making and fraught with inauthenticity.

Cultural competence requires a willingness to acknowledge our biases so as not to unconsciously enact them. Humans are biologically wired to respond to difference, and psychosocially conditioned to associate difference with something wrong or dangerous. This is even more true when the person we are dealing with represents the unthinkable—the experience of trauma.

Finally, culturally competent practice says that each human being represents the range of aspects of diversity, and that being culturally competent requires awareness of one's own identities and social locations as well as those of clients. Pamela Hays's has developed the ADDRESSING model for understanding the complexity and diversity of all humans' identities. It stands for A: Age-related factors, including chronological age and age cohort; DD: Disability/ability, developmental and acquired, visible and invisible; R: Religion and spirituality; E: Ethnic origins; race/phenotype, culture; S: Social class; S: Sexual orientation; I: Indigenous heritage; N: National origin; G: Gender/biological sex.

Trauma is another component of identity. It can stand along, or be linked to any of the ADDRESSING locations. Individuals may also attribute, accurately or not, their experiences of victimization to some component of their identities, and struggle with hatred for an inescapable fact about themselves that they believe rendered them vulnerable.

Becoming culturally competent in work with trauma survivors is a process where one never quite arrives at the conclusion. Cultural competence requires on-going consultation and training in addition to continuing acquisition of specific knowledge; one is never culturally competent; one is always moving towards it. But like the objects in the mirror, it is closer than we think, and worth the journey.

Suggested Additional Readings

Brown, L.S. (2008). *Cultural competence in trauma treatment: Beyond the flashback*. Washington DC: American Psychological Association.

Gaertner, S. & Dovidio, J. (1986). The aversive form of racism. In J. Dovidio, & S. Gaertner (Eds.), *Prejudice, discrimination and racism*. Orlando, FL: Academic Press.

Herman, J L. (1992). *Trauma and recovery*. New York: Basic Books.

Hays, P. A. (2007). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy*. Washington DC: American Psychological Association.